FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039321

Facility Name: Glenshire Nursing & Rehab Ctre

Address: 22660 South Cicero Avenue (Number) Richton Park (City) 60471 (Zip Code)

County: Cook

Telephone Number: (708) 747-6120 **Fax #** (708) 747-6491

IDPA ID Number: 3639399006001

Date of Initial License for Current Owners: 3/23/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer Telephone Number: (312) 634-3400
Please send copies of any audit adjustments to address above.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) SEE ACCOUNTANTS' COMPILATION REPORT

(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One S. Wacker Drive, Suite 800, Chicago IL 60606-3392

(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,830	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,480	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	294	TOTALS	294	107,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,331	2,139	6,729	45,199	8
9	SNF/PED					9
10	ICF	35,939	1,179	550	37,668	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,270	3,318	7,279	82,867	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.22%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 5,564

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,143	60,042	22,740	404,925		404,925		404,925			1
2	Food Purchase		496,651		496,651	(25,982)	470,669		470,669			2
3	Housekeeping	238,839	90,647		329,486		329,486		329,486			3
4	Laundry	146,689	8,318	13,896	168,903		168,903		168,903			4
5	Heat and Other Utilities			184,231	184,231		184,231	6,086	190,317			5
6	Maintenance	99,103	40,978	111,810	251,891		251,891	9,950	261,841			6
7	Other (specify):*											7
8	TOTAL General Services	806,774	696,636	332,677	1,836,087	(25,982)	1,810,105	16,036	1,826,141			8
	B. Health Care and Programs											
9	Medical Director			24,900	24,900		24,900		24,900			9
10	Nursing and Medical Records	3,331,160	803,236	36,726	4,171,122		4,171,122	(243,220)	3,927,902			10
10a	Therapy	128,339	1,327	467,481	597,147		597,147		597,147			10a
11	Activities	182,989	9,236	2,160	194,385		194,385		194,385			11
12	Social Services	127,017		2,500	129,517		129,517		129,517			12
13	Nurse Aide Training											13
14	Program Transportation			815	815		815		815			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,769,505	813,799	534,582	5,117,886		5,117,886	(243,220)	4,874,666			16
	C. General Administration											
17	Administrative	158,505		1,449,636	1,608,141		1,608,141	(1,449,636)	158,505			17
18	Directors Fees											18
19	Professional Services			112,039	112,039		112,039	17,783	129,822			19
20	Dues, Fees, Subscriptions & Promotions			30,915	30,915		30,915	1,027	31,942			20
21	Clerical & General Office Expenses	476,650	54,691	36,887	568,228		568,228	33,942	602,170			21
22	Employee Benefits & Payroll Taxes			721,959	721,959	25,982	747,941	64,146	812,087			22
23	Inservice Training & Education			1,410	1,410		1,410	495	1,905			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,879	4,879		4,879	1,884	6,763			25
26	Insurance-Prop.Liab.Malpractice			288,453	288,453		288,453	1,021	289,474			26
27	Other (specify):*											27
28	TOTAL General Administration	635,155	54,691	2,646,178	3,336,024	25,982	3,362,006	(1,329,338)	2,032,668			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,211,434	1,565,126	3,513,437	10,289,997		10,289,997	(1,556,522)	8,733,475			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre #0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			92,832	92,832		92,832	506,246	599,078			30
31	Amortization of Pre-Op. & Org.			6,693	6,693		6,693	(6,693)				31
32	Interest			(21)	(21)		(21)	823,651	823,630			32
33	Real Estate Taxes							760,867	760,867			33
34	Rent-Facility & Grounds			2,466,298	2,466,298		2,466,298	(2,466,298)				34
35	Rent-Equipment & Vehicles			22,337	22,337		22,337	12,014	34,351			35
36	Other (specify):*							55,918	55,918			36
37	**TOTAL Ownership**			2,588,139	2,588,139		2,588,139	(314,295)	2,273,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		342,599	14,952	357,551		357,551		357,551			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,968	160,968		160,968		160,968			42
43	Other (specify):* **Non-Allowable**			171,803	171,803		171,803	(171,803)				43
44	**TOTAL Special Cost Centers**		342,599	347,723	690,322		690,322	(171,803)	518,519			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,211,434	1,907,725	6,449,299	13,568,458		13,568,458	(2,042,620)	11,525,838			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27,737)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(883)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,965)	43		18
19	Entertainment	(4,951)	43		19
20	Contributions	(1,600)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(155,942)	43		24
25	Fund Raising, Advertising and Promotional	(758)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,521)	43		28
29	Other-Attach Schedule See Attached Schedule F	(244,662)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (444,019)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(6,693)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,591,908)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,598,601)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,042,620)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X	94,464	Ln39,Co2	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 94,464		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Glenshire Nursing & Rehab Ctre

ID# 0039321

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust Mgt. Co. Medical Supplies "A" To Cost	$ (198,215)	10	1
2	Adjust Mgt. Co. Medical Supplies "Other" To Cost	(45,005)	10	2
3	Patient Clothing	(183)	43	3
4	Amortization of 2002 Deferred Maintenance	4,332	6	4
5	Non-Allowable Professional Fees	(4,591)	19	5
6	Non-Allowable Bank Fees	(1,000)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(244,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	6,086	0	0	0	0	0	0	0	0	6,086	5
6	Maintenance	4,332	0	5,618	0	0	0	0	0	0	0	0	9,950	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	4,332	0	11,704	0	0	0	0	0	0	0	0	16,036	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(243,220)	0	0	0	0	0	0	0	0	0	0	(243,220)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(243,220)	0	0	0	0	0	0	0	0	0	0	(243,220)	16
	C. General Administration													
17	Administrative	0	0	(387,136)	(1,062,500)	0	0	0	0	0	0	0	(1,449,636)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,591)	0	22,374	0	0	0	0	0	0	0	0	17,783	19
20	Fees, Subscriptions & Promotions	0	0	1,027	0	0	0	0	0	0	0	0	1,027	20
21	Clerical & General Office Expenses	0	0	33,322	0	620	0	0	0	0	0	0	33,942	21
22	Employee Benefits & Payroll Taxes	0	0	64,146	0	0	0	0	0	0	0	0	64,146	22
23	Inservice Training & Education	0	0	495	0	0	0	0	0	0	0	0	495	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	1,884	0	0	0	0	0	0	0	0	1,884	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,021	0	0	0	0	0	0	0	0	1,021	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,591)	0	(262,867)	(1,062,500)	620	0	0	0	0	0	0	(1,329,338)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(243,479)	0	(251,163)	(1,062,500)	620	0	0	0	0	0	0	(1,556,522)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	25,910	0	480,336	0	0	0	0	0	0	506,246	30
31	Amortization of Pre-Op. & Org.	(6,693)	0	0	0	0	0	0	0	0	0	0	(6,693)	31
32	Interest	(27,737)	0	9,718	0	841,670	0	0	0	0	0	0	823,651	32
33	Real Estate Taxes	0	0	11,529	0	749,338	0	0	0	0	0	0	760,867	33
34	Rent-Facility & Grounds	0	0	0	0	(2,466,298)	0	0	0	0	0	0	(2,466,298)	34
35	Rent-Equipment & Vehicles	0	0	12,014	0	0	0	0	0	0	0	0	12,014	35
36	Other (specify):*	0	0	0	0	55,918	0	0	0	0	0	0	55,918	36
37	**TOTAL Ownership**	(34,430)	0	59,171	0	(339,036)	0	0	0	0	0	0	(314,295)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(172,803)	0	0	0	1,000	0	0	0	0	0	0	(171,803)	43
44	**TOTAL Special Cost Centers**	(172,803)	0	0	0	1,000	0	0	0	0	0	0	(171,803)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(450,712)	0	(191,992)	(1,062,500)	(337,416)	0	0	0	0	0	0	(2,042,620)	45

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sidney Glenner	80.00 %	GlenBridge Nursing & Rehabilitation Centre,Ltd	Niles	SEE ATTACHED SCHEDULE A		
Barry Ray	20.00 %	GlenCrest Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glen Elston Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glen Oaks Nursing & Rehabilitation Centre,Ltd	Northbrook			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V		Total from Page 6A	387,136	Glen Health and Home Management, Inc.	A	195,144	(191,992)	2
3	V								3
4	V		Total from Page 6B	1,062,500	GlenBar Management Company, Ltd.	B		(1,062,500)	4
5	V								5
6	V		Total from Page 6C	2,466,298	GlenShire Real Estate and Development Limited Partnership	C	2,128,882	(337,416)	6
7	V								7
8	V								8
9	V				OWNERSHIP REFERENCE:				9
10	V				A: Owned 100.00 % by Sidney Glenner through attribution				10
11	V				B: Owned 80.00 % by Sidney Glenner & 20.00 % by Barry Ray				11
12	V				C: Owned 60.00 % (constructively) by Sidney Glenner & 20.00 % by Barry Ray				12
13	V								13
14	Total			$ 3,915,934			$ 2,324,026	$ * (1,591,908)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 387,136	Glen Health and Home Management, Inc.	A	$	$ (387,136)	15
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	6,086	6,086	16
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	5,618	5,618	17
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	22,374	22,374	18
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,027	1,027	19
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	33,322	33,322	20
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	64,146	64,146	21
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	495	495	22
23	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	1,884	1,884	23
24	V	26	Insurance		Glen Health and Home Management, Inc.	A	1,021	1,021	24
25	V	32	Amortization of Mortgage Costs		Glen Health and Home Management, Inc.	A	96	96	25
26	V	30	Depreciation		Glen Health and Home Management, Inc.	A	25,910	25,910	26
27	V	32	Interest		Glen Health and Home Management, Inc.	A	9,622	9,622	27
28	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	11,529	11,529	28
29	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	12,014	12,014	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 387,136			$ 195,144	$ * (191,992)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$ 1,062,500	GlenBar Management Company, Ltd.	B	$	$ (1,062,500)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,062,500			$ 0	$ * (1,062,500)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical	$	GlenShire Real Estate & Development Limited Partnership	C	$ 620	$ 620	15
16	V	43	Bank Fees		GlenShire Real Estate & Development Limited Partnership	C	1,000	1,000	16
17	V	30	Depreciation		GlenShire Real Estate & Development Limited Partnership	C	480,336	480,336	17
18	V	32	Interest Income		GlenShire Real Estate & Development Limited Partnership	C	(37,553)	(37,553)	18
19	V	32	Interest Expense		GlenShire Real Estate & Development Limited Partnership	C	866,975	866,975	19
20	V	33	Real Estate Taxes		GlenShire Real Estate & Development Limited Partnership	C	749,338	749,338	20
21	V	34	Rental Income	2,466,298	GlenShire Real Estate & Development Limited Partnership	C		(2,466,298)	21
22	V	32	Amortization of Mortgage Costs		GlenShire Real Estate & Development Limited Partnership	C	12,248	12,248	22
23	V	36	Mortgage Insurance Premium		GlenShire Real Estate & Development Limited Partnership	C	55,918	55,918	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,466,298			$ 2,128,882	$ * (337,416)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Sidney Glenner	President	Administrative	80.00 %	130,168	13	22.30 %	Salary	$ 32,583	Ln 17, Col 1	1
2	Barry Ray	Vice President	Administrative	20.00 %	130,168	9	22.30 %	Salary	32,583	Ln 17, Col 1	2
3	David Glenner	Vice President	Administrative	0.00 %	65,084	9	22.30 %	Salary	16,291	Ln 17, Col 1	3
4											4
5											5
6			See Schedule B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 81,457		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Glen Health & Home Management, Inc.
Street Address: 5454 West Fargo Avenue
City / State / Zip Code: Skokie, Il 60077
Phone Number: (847) 674-5454
Fax Number: (847) 674-8311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	414,299	5	$ 30,429	$	82,867	$ 6,086	1
2	6	Repairs and Maintenance	Patient Days	414,299	5	28,086		82,867	5,618	2
3	19	Professional Fees	Patient Days	414,299	5	111,859		82,867	22,374	3
4	20	Licenses,Permit and Inspection	Patient Days	414,299	5	5,133		82,867	1,027	4
5	21	Clerical	Patient Days	414,299	5	166,594		82,867	33,322	5
6	22	Employee Benefits and Payroll	Patient Days	414,299	5	320,704		82,867	64,146	6
7	23	Training and Education	Patient Days	414,299	5	2,476		82,867	495	7
8	25	Auto Expenses	Patient Days	414,299	5	9,421		82,867	1,884	8
9	26	Insurance	Patient Days	414,299	5	5,107		82,867	1,021	9
10	32	Amortization of Mortgage Cost	Patient Days	414,299	5	481		82,867	96	10
11	30	Depreciation	Patient Days	414,299	5	129,539		82,867	25,910	11
12	32	Interest	Patient Days	414,299	5	48,108		82,867	9,622	12
13	33	Real Estate Taxes	Patient Days	414,299	5	57,641		82,867	11,529	13
14	35	Equipment and Vehicle Rental	Patient Days	414,299	5	60,066		82,867	12,014	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 975,644	$		$ 195,144	25

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Allfirst Mortgage Corporation		X	Mortgage	$179,447.81	3/16/96	$ 12,973,600	$ 11,018,997	4/01/2018	.0775	$ 866,975	1
2	Allfirst Mortgage Corporation		X	Amortization of mortgage costs							12,248	2
3							Mortgage interest allocated from Management Comp:				22,568	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$179,447.81		$ 12,973,600	$ 11,018,997			$ 901,791	9
	B. Non-Facility Related*											
10									Interest Income Offset:		(78,161)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (65,311)	14
15	TOTALS (line 9+line14)						$ 12,973,600	$ 11,018,997			$ 823,630	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 682,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 703,338	2
3. Under or (over) accrual (line 2 minus line 1).		$ 21,338	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 728,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 749,338	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	624,000	8
	1998	642,858	9
	1999	648,110	10
	2000	658,315	11
	2001	703,338	12

See Attached Schedule G For Calculation of 2002 Real Estate Tax Accrual.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenshire Nursing & Rehab Ctre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039321

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-3400 FAX #: (312) 634-5518

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	31-34-100-012-0000	22660 S. Cicero Ave, Richton Park IL	$ 703,338.03	$ 703,338.03
2.	See attached schedule for home office allocation		$ 57,641.00	$ 11,529.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 760,979.03	$ 714,867.03

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,624 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Four

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	146,800	1994	$ 300,792	1
2	Allocated from Management Company:			22,320	2
3	TOTALS	146,800		$ 323,112	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	294		1994	1981	$ 11,663,928	$	30	$ 388,798	$ 388,798	$ 3,434,379	4
5											5
6	Alloc from				404,357			8,364	8,364		6
7	Mgt Comp										7
8	ScheduleJ										8
	Improvement Type**										
9	Building Improvements			1994	78,204	7,820	10	7,820		66,473	9
10	Building Improvements			1995	107,573	10,757	10	10,757		82,472	10
11	Custom built 3rd floor nurses station			1995	6,595	660	10	660		4,400	11
12	Time delay egress locks and keypad			1995	3,550	355	10	355		2,366	12
13	Chimney			1995	1,016	102	10	102		680	13
14	Wall bumpers			1995	7,713	771	10	771		5,141	14
15	Room conversion - remodeling cost			1996	7,024	702	10	702		4,680	15
16	Electrical outlets and circuits			1997	18,500	1,850	10	1,850		10,483	16
17	Electrical outlets and circuits - dialysis room			1997	2,950	295	10	295		1,672	17
18	Air cleaner			1997	1,375	138	10	138		780	18
19	Fluorescent and incandescent lights			1997	9,775	978	10	978		5,540	19
20	Waste removal pump			1997	993	99	10	99		562	20
21	Boiler			1997	3,169	317	10	317		1,796	21
22	Food freezer floor			1997	2,700	270	10	270		1,260	22
23	New elevator clutch assembly			1997	1,644	164	10	164		766	23
24	Heat exchange for boiler			1997	2,392	239	10	239		1,116	24
25	Gazebo			1998	10,528	1,053	10	1,053		4,913	25
26	Fire sprinkler system repairs			1998	1,604	160	10	160		748	26
27	Security system			1998	1,917	192	10	192		895	27
28	Storage tank			1998	4,875	488	10	488		2,276	28
29	Elevator repairs			1998	2,706	271	10	271		1,264	29
30	HVAC replacements			1998	3,855	386	10	386		1,800	30
31	Hydraulic repack on all elevators			1998	2,500	250	10	250		1,167	31
32	Replace water heater			1998	2,697	270	10	270		1,259	32
33	Chain link fencing			1998	2,010	201	10	201		938	33
34	Elevator repairs			1998	2,747	275	10	275		1,283	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Therapy room remodeling: drywall, electrical closet, piping	1998	$ 8,525	$ 853	10	$ 853	$	$ 3,127	37
38	Dialysis room: kitchen area	1998	2,757	276	10	276		1,011	38
39	10-B label fire rated doors	1999	4,376	438	10	438		1,606	39
40	Install cooling units in elevator and MDS office	1999	11,649	1,165	10	1,165		3,593	40
41	Mini-blinds	1998	1,565	157	10	157		731	41
42	November 30, 1998 credit	1998	(1,755)	(176)	10	(176)		(645)	42
43	Add suction and liquid filters to compressor	2000	3,982	398	10	398		995	43
44	Replace wood fence	2000	2,300	230	10	230		575	44
45	Asphalt & striping project	2000	8,365	836	10	836		2,090	45
46	Metal doors, install lighting by staircase	2000	6,010	601	10	601		1,503	46
47	Install alarm with keypad at front door	2000	1,177	118	10	118		295	47
48	Furnish & install 9,000 BTU mini air-conditioner system	2000	2,200	220	10	220		550	48
49	Install ceramic tiles	2000	1,373	138	10	138		345	49
50	Power rinse tank for dish washing machine	2001	2,594	259	10	259		389	50
51	Rebuild condenser water pump	2001	5,198	520	10	520		780	51
52	Install two grey boxes and mixing valves	2001	4,111	411	10	411		617	52
53	Install portable chiller	2001	2,891	289	10	289		434	53
54	Provide panel and circuiting to feed 20 dialysis receptacles	2001	10,914	1,091	10	1,091		1,637	54
55	Circulating pump	2001	3,385	339	10	339		508	55
56	Exterior lock doors	2001	3,423	342	10	342		513	56
57	Painting project	2002	11,500	575	10	575		575	57
58	Vinyl blinds	2002	8,765	438	10	438		438	58
59	Installation of fire dampers and thermal blankets	2002	5,318	266	10	266		266	59
60	Dialysis room renovation	2002	14,500	725	10	725		725	60
61	Replace controller on air-conditioner	2002	3,570	178	10	178		178	61
62	Painting project	2002	9,540	477	10	477		477	62
63	Installation of chemical treatment system	2002	2,300	115	10	115		115	63
64	Roof project	2002	3,350	168	10	168		168	64
65	Remove and replace concrete patio	2002	1,800	90	10	90		90	65
66	Pro Tech Systems project	2002	1,793	90	10	90		90	66
67									67
68	Allocated from Management Company:		32,190			7,014	7,014	13,406	68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,538,563	$ 40,690		$ 444,866	$ 404,176	$ 3,678,291	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,411,386	$ 142,591	$ 142,591	$	5,10 years	$ 1,049,280	71
72	Current Year Purchases	21,761	1,088	1,088		10 years	1,088	72
73	Fully Depreciated Assets	32,861				5 years	32,861	73
74	Allocated from Management Company:	162,702		7,783	7,783		31,059	74
75	TOTALS	$ 1,628,710	$ 143,679	$ 151,462	$ 7,783		$ 1,114,288	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management Company:			$ 22,909	$	$ 2,750	$ 2,750		$ 15,747	76
77										77
78										78
79										79
80	TOTALS			$ 22,909	$	$ 2,750	$ 2,750		$ 15,747	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,513,294	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 184,369	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 599,078	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 414,709	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,808,326	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☒ X NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 25,208 Description: Copier$7,865,Ice-maker$2,170,Postage meter$652,Chiller$8,365,Med Equip$3,285,Mgt Co Alloc$2,871
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Management Company:		$	$ 9,143	17
18					18
19					19
20					20
21	TOTAL		$	$ 9,143	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
* It is the policy of this facility to hire only certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

[ ] YES
[X] NO

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:
IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 10a,Col 2&3	hrs	$	6,140	$ 214,913	$ 1,278	6,140	$ 216,191	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		494	17,283		494	17,283	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		6,397	223,203	49	6,397	223,252	4
5	Physician Care	Ln 39, Col 3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				248,135		248,135	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 2					94,464		94,464	12
13	Respiratory Therapy Other (specify): Radiology&Labortry	Ln 10a, Col 1 Ln 39, Col 3	4278 hrs	128,339		14,952		4,278	128,339 14,952	13
14	TOTAL			$ 128,339	13,031	$ 470,351	$ 343,926	17,309	$ 942,616	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 528,905	$ 2,527,086	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,024)	3,378,293	3,378,293	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,884	168,325	6
7	Other Prepaid Expenses	580	580	7
8	Accounts Receivable (owners or related parties)	(80,853)	(10,149)	8
9	Other(specify): Employee Loans Receivable	4,603	4,603	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,981,412	$ 6,068,738	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		323,112	13
14	Buildings, at Historical Cost		12,068,285	14
15	Leasehold Improvements, at Historical Cost	434,798	470,278	15
16	Equipment, at Historical Cost	550,620	1,651,619	16
17	Accumulated Depreciation (book methods)	(505,144)	(4,808,326)	17
18	Deferred Charges		1,632	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,029,217	21
22	Other Long-Term Assets (spe Goodwill	42,470	42,470	22
23	Other(specify): Mortgage Costs (Net)		186,275	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 522,744	$ 10,964,562	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,504,156	$ 17,033,300	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,111	$ 47,111	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,980	11,980	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	257,493	257,493	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,587	7,587	31
32	Accrued Real Estate Taxes(Sch.IX-B)		728,000	32
33	Accrued Interest Payable		71,164	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule E:	842,760	842,760	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,166,931	$ 1,966,095	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,018,997	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To Officers	3,927,500	3,927,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,927,500	$ 14,946,497	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,094,431	$ 16,912,592	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (590,275)	$ 120,708	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,504,156	$ 17,033,300	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (490,270)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (490,270)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(100,005)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (100,005)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (590,275)	24

* Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,035,382	1
2	Discounts and Allowances for all Levels	(1,946,725)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,088,657	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,226,175	6
7	Oxygen	663,880	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,890,055	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	412,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,934	19
20	Radiology and X-Ray	6,395	20
21	Other Medical Services	1,027,829	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,461,236	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,737	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,737	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	103	28
28a	Private Bedhold	665	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 768	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,468,453	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,836,087	31
32	Health Care	5,117,886	32
33	General Administration	3,336,024	33
	B. Capital Expense		
34	Ownership	2,588,139	34
	C. Ancillary Expense		
35	Special Cost Centers	529,354	35
36	Provider Participation Fee	160,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,568,458	40
41	**Income before Income Taxes (line 30 minus line 40)****	(100,005)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (100,005)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,134	2,324	$ 68,515	$ 29.48	1
2	Assistant Director of Nursing	3,233	3,509	91,919	26.20	2
3	Registered Nurses	34,111	36,012	909,333	25.25	3
4	Licensed Practical Nurses	45,459	48,606	976,516	20.09	4
5	Nurse Aides & Orderlies	98,712	105,610	1,002,109	9.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,768	6,229	128,339	20.60	7
8	Rehab/Therapy Aides	11,965	12,595	154,663	12.28	8
9	Activity Director	3,549	3,762	44,018	11.70	9
10	Activity Assistants	13,680	15,316	138,971	9.07	10
11	Social Service Workers	11,685	12,765	127,017	9.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,912	4,051	42,780	10.56	14
15	Cook Helpers/Assistants	32,745	34,570	279,363	8.08	15
16	Dishwashers					16
17	Maintenance Workers	7,827	8,295	99,103	11.95	17
18	Housekeepers	27,828	29,880	238,839	7.99	18
19	Laundry	16,806	18,412	146,689	7.97	19
20	Administrator	2,301	2,425	50,174	20.69	20
21	Assistant Administrator	2,231	2,364	26,874	11.37	21
22	Other Administrative	1,612	1,612	81,457	50.53	22
23	Office Manager					23
24	Clerical	39,893	42,439	476,650	11.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,895	4,464	49,220	11.03	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerks	4,330	4,790	78,885	16.47	33
34	TOTAL (lines 1 - 33)	373,676	400,030	$ 5,211,434 *	$ 13.03	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 22,740	Ln 1, Col 3	35
36	Medical Director	Monthly	24,900	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,220	Ln 10,Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,160	Ln 11, Col 3	44
45	Social Service Consultant	50	2,500	Ln 12, Col 3	45
46	Other(specify)				46
47	Medical Librarian	16	690	Ln 10,Col 3	47
48					48
49	TOTAL (lines 35 - 48)	114	$ 55,210		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,432	$ 35,792	Ln 10,Col 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,432	$ 35,792		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sidney Glenner	Administrative	80.00 %	$ 32,583
Barry Ray	Administrative	20.00 %	32,583
David Glenner	Administrative	0.00 %	16,291
Ken Haack	Administrator	0.00 %	50,174
Caryl Kiser	Asst Administrator	0.00 %	26,874
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 158,505

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 1,449,636
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,449,636
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Computers	$ 6,733
Advanced Information Mgt.	Computers	4,842
Kronos, Inc.	Computers	1,711
American Express Tax Services	Accounting	32,153
Sachnoff & Weaver, Ltd.	Legal	17,780
Janna Dutton & Associates	Legal	1,396
Admiral Insurance Company	Legal	5,000
Winston & Strawn	Legal	1,470
Burke , Warren & MacKay, P.C.	Legal	(3,133)
Littler Mendelson	Unemployment Consulting	18,012
Evelyn Troike	Operations Consulting	16,500
ProTech Systems, Ltd.	Maintenance Consulting	9,575
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 112,039

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,358
Unemployment Compensation Insurance	53,670
FICA Taxes	368,116
Employee Health Insurance	127,561
Employee Meals	25,982
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	37,666
Uniform Allowance	131
401K Match	2,456
Profit Sharing	35,821
Other Employee Benefits	7,183
Employee Medical Reimbursement	2,680
Allocated from Management Company:	61,463
TOTAL (agree to Schedule V, line 22, col.8)	$ 812,087

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,166
Health Care Worker Background Check	294
(Indicate # of checks performed 42)	
Illinois Council on Long Term Dues	15,585
Elevator Inspections	520
Secretary of State Annual Report	50
Vending Machine Permits	120
Equipment Inspections	180
Allocated from Management Company:	1,027
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,942

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Repairs & Maintenance	1998	$ 5,362	3years	$ 1,787	$ 1,787	$ 894	$	$	$	$	$	$
2	Painting & Decorating	1999	12,667	3years	2,111	4,222	4,222	2,112					
3	Painting & Decorating	2000	5,094	3years		849	1,698	1,698	849				
4	Painting & Decorating	2001	1,566	3years			261	522	522	261			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 24,689		$ 3,898	$ 6,858	$ 7,075	$ 4,332	$ 1,371	$ 261	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $15,585**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,946** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **160,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,982** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0039321
12/31/02

SCHEDULE A

SCHEDULE VII. RELATED PARTIES
Part A. Col.3

3 OTHER RELATED BUSINESS ENTITIES		
Name	**City**	**Type of Business**
Glen Health & Home Management, Inc.	Skokie	Management Company
GlenBar Management Company, Ltd.	Skokie	Management Company
GlenShire Real Estate & Development Limited Partnership	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Company
Therapy Masters	Skokie	Therapy company
GlenCare At Home, Ltd.	Skokie	Home Health agency
GlenCare Home Health, Ltd.	Skokie	Home Health agency
GlenCare Private Duty, Ltd.	Skokie	Home Health agency

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, LTD.
Provider # 0039321
12/31/2002

SCHEDULE B

SCHEDULE VII RELATED PARTIES

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

	Compensation Received From Other Nursing Homes				
Name	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenBridge Nursing & Rehab. Centre, Ltd.	Total
Sidney Glenner	14,908	39,239	39,565	36,456	130,168
David Glenner	7,454	19,620	19,782	18,228	65,084
Barry Ray	14,908	39,239	39,565	36,456	130,168
Total compensation received from other Nursing Homes	37,270	98,098	98,912	91,140	325,420

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/02

XIX. SUPPORT SCHEDULES **SCHEDULE C**

C. Professional Services
Page 21

DESCRIPTION	AMOUNT
Total Schedule V, Line 19, Col. 3	112,039
Allocated from Management Co:	
Sachnoff & Weaver, Ltd. - Legal Services	54
American Express - Accounting Services	19,146
Schiller, Klein & McElroy - Legal Services	2,017
Frost, Ruttenberg - Accounting Services	428
Littler Mendelson - Legal Services	562
Ross Hardies - Legal Services	167
Total allocated from Management Co:	22,374
Non-allowable Professional Fees:	
Sachnoff & Weaver, Ltd.	(6,254)
Winston & Strawn	(1,470)
Burke, Warren & MacKay, P.C. Out of period credits	3,133
Total Non-allowable Professional Fees	(4,591)
Total adjustments page 21, Sch C.	17,783
Total Schedule V, line 19, column 8	129,822

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/02

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

DESCRIPTION	AMOUNT
Allocated from Management Co.	
FICA taxes	21,845
FUTA	349
SUTA	1,371
401K Match	1,371
Insurance - Hospital	25,398
Other Employee Benefits	1,046
Workers Compensation Insurance	666
Profit Sharing Plan Contribution	9,417
Total allocated from Management Co.	61,463

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/02

SCHEDULE E

XV. SUPPORT SCHEDULES

Page 17, Line 36

DESCRIPTION	AMOUNT
Refunds Exchange	-17,148
Accrued Wage Assignment	-2,055
Credit Union	-430
Sundry Payable	399,349
Accrued Union Dues	3,541
Accrued Management Fees	277,083
Accrued Profit Sharing	58,000
Due to Third Party	124,621
Due Con. Mutual	-415
Due To Prior Owner	214
Total, Page 17, Line36	842,760

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/02

SCHEDULE F

PAGE 5, SCHEDULE VI. ADJUSTMENT DETAIL
Schedule A. Nonallowable Expenses
Line 29 - Other Non-allowable costs

Description	Amount	Reference
Patient Clothing	(183)	43
Non-allowable professional fees	(4,591)	19
Adjust mgt. co. med supplies - med'a' to cost	(198,215)	10
Adjust mgt. co. med supplies - 'other' to cost	(45,005)	10
Amortization of current year deferred maintenance	4,332	6
Non-allowable bank fees	(1,000)	43
Total	(244,662)	

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GlenShire Real Estate & Development, LLC
Accrued Real Estate Taxes
12/31/02

SCHEDULE G

		Accrued 1/1/2002	Payments	Expense	Accrued 12/31/2002
Balance @ 1/01/02		(682,000.00)		(682,000.00)	
2001 real estate taxes paid			703,338.03	703,338.03	
Estimated 2002 real estate taxes:					
2001 taxes	703,338.03				
Estimated increase	3.50%				
Estimated 2002 taxes	727,954.86				
USE	728,000.00			728,000.00	(728,000.00)
Totals		(682,000.00)	703,338.03	749,338.03	(728,000.00)

Real estate tax history:

Year	Amount	Increase $	Increase %
1991	443,164.00		
1992	465,682.00	22,518.00	5.08%
1993	529,742.00	64,060.00	13.76%
1994	545,165.38	15,423.38	2.91%
1995	582,936.44	37,771.06	6.93%
1996	601,796.63	18,860.19	3.24%
1997	624,000.41	22,203.78	3.69%
1998	642,857.87	18,857.46	3.02%
1999	648,110.27	5,252.40	0.82%
2000	658,314.50	10,204.23	1.57%
2001	703,338.03	45,023.53	6.84%

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider I.D. #0039321
December 31, 2002

SCHEDULE H

Page 3, Schedule V, Line 23, Col. 8
Inservice Training and Education

Training Material or Person(s) Attending	Date Attended	Location	Title Sponsor / Vendor	Total Cost
COLLEEN KAMIN, AMY MANIKOWSKI CHRISTINE KOZMINSKI, KATHY DAVIS	1/17/02	LINCOLNWOOD	IL COUNCIL ON LONG TERM CARE - THE 2002 MDS WORKSHOP: GETTING IT ALL GETTING IT RIGHT	300.00
DIETARY STAFF	5/13/02	FACILITY	SANISAFE - SANITATION INSERVICE	130.00
KATHY DAVIS	8/23/02	SPRINGFIELD	ILLINOIS HEALTH CARE ASSOCIATION - REVIEW COURSE FOR THE ILLINOIS LICENSURE EXAMINATION FOR NURSING HOME ADMINISTRATORS	900.00
DIETARY STAFF	9/26/02	FACILITY	CYNTHIA CHOW & ASSOCIATES FOOD PREPARATION	80.00
MANAGEMENT COMPANY ALLOCATION				495.24
TOTAL INSERVICE TRAINING AND EDUCATION				1,905.24

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, LTD.
Provider #0039321
12/31/2002

SCHEDULE I

Page 3, Schedule V, Line 25, Col 8
Other Admin. Staff Transportation

	Gasoline	Repairs	Mileage Reimb.	Total
Direct Expense	2,694	685	1,500	4,879
Allocated from Management Company				1,884
TOTAL	2,694	685	1,500	6,763

See Accountants' Compilation Report

HEALTH AND HOME MANAGEMENT, INC.
ALLOCATION OF MANAGEMENT COMPANY BUILDING

SCHEDULE J

ASSET DESCRIPTION	COST 6/30/1999	ADJUSTMENTS TO CAPITAL PROJECTION	ADJUSTED CAPITAL PROJECTION 6/30/1999	ADDITIONS 7/1/99- 12/31/2000	COST 12/31/2000	NURSING HOME PERCENTAGE 84.9438%	GLENBRIDGE 103,052/460292 0.223883969	GLENCREST 111,372/460,292 0.241959452	GLEN OAKS 101,895/460,292 0.221370348	GLEN ELSTON 41,220/460,292 0.08955185	**GLENSHIRE** 102,753/460,292 0.223234382
1996 BUILDING PURCHASE	230,000		230,000		230,000	195,371	43,740	47,272	# 43,249	# 17,496	43,613
1998 BUILDING RENOVATION											
GENERAL CONTRACTOR	957,570		957,570		957,570						
ELECTRICAL CONTRACTOR	275,576		275,576		275,576						
HVAC CONTRACTOR	182,130		182,130		182,130						
PLUMBING CONTRACTOR	68,599		68,599		68,599						
ARCHITECT FEES	115,968		115,968		115,968						
OTHER FEES AND PERMITS	33,024		33,024		33,024						
SECURITY SYSTEM	17,953		17,953		17,953						
TELEPHONE SYSTEM	12,500		12,500		12,500						
MISC. BUILDING COMPONENTS	24,226	-15,261	24,226		24,226						
CAPITALIZED INTEREST	121,387		106,126		106,126						
LANDSCAPING	30,000		30,000		30,000						
SPRINKLER SYSTEM	10,720	-24,749	10,720		10,720						
HVAC SYSTEMS	24,749	-10,235	0								
WALL CONSTRUCTION	10,235	-10,634	0								
ELECTRICAL	10,634	-26,075	0								
MISC. IMPROVEMENTS	26,075	-5,900	0								
ASPHALT DRIVEWAY	5,900		0								
					1,834,392	1,558,202	348,857	377,022	# 344,940	# 139,540	347,844
1999 ACCORD ELECTRIC				17,929	17,929						
HMS + ASSOCIATES-INTERIOR				31,505	31,505						
SAM MORMINO-LANDSCAPING				1,050	1,050						
ARCHITECTURAL DYNAMICS-ARCHITECT FEES				1,468	1,468						
MISC.				11,076	11,076						
					63,028	53,538	11,986	12,954	# 11,852	# 4,794	11,952
2000 AQUATIC WORKS - BUILT-IN FISH TANK				5,000							
					5,000	4,247	951	1,028	# 940	# 380	948
2001 NO ADDITIONS											
2002 NO ADDITIONS											
					2,132,420	1,811,359	405,534	438,276	400,981	162,210	404,357

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